HOUSEHOLD MEMBERS **~DO NOT USE THIS FORM~**

Caregiver Medical Statement (All Modalities)

(CHECK ONE) ☐ Provider ☐ Substitute ☐ Volunteer ☐ Director ☐ Assistant ☐ Teacher ☐ Other Staff

INSTRUCTIONS

Submit

Maintain On-Site

- *A signature is required on both pages of this form.*
- *Only a health care provider (physician, physician's assistant, nurse practitioner) may complete and sign the Medical Condition section*
- ***A registered nurse is NOT authorized to sign the Medical Condition section***
- *A health care provider may use an equivalent form as long as the information on this form is included*

Applicant Name:	Date of Birth:

Typical Duties of Day Care Program

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Desk work
- Driver of vehicle
- Food preparation
- Facility maintenance
- Evacuation of children in an emergency

Medical Condition

Date of Exam: _____ /_____ /_____

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is physically fit to provide child day care and perform the duties listed above. ☐ **YES** *(symptom free)* ☐ **NO** *(NOT symptom free)*
- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted during day care. ☐ **YES** *(symptom free)* ☐ **NO** *(NOT symptom free)*
- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children. ☐ **YES** *(symptom free)* ☐ **NO** *(NOT symptom free)*

For any "No" responses, indicate Restrictions: _____

_____

_____

_____

Signature *(physician, physician's assistant, nurse practitioner)*	
Name *(Please PRINT clearly)*	**Title**
( ) -	**/ /**
Phone	**Date**

(Continued on reverse)

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LDSS-4434-1 (Rev. 5/2011) Reverse

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INSTRUCTIONS

Submit **Maintain On File**

- *A health care provider (physician, physician's assistant, nurse practitioner) or a registered nurse (as part of their duties at a health care facility) may enter the Mantoux results in the TB section and sign this page*

Applicant Name:	Date of Birth:

Following to be completed by Health Professional ONLY

Tuberculin Test Information

Test Read on: _____ (mm / dd / yyyy) ☐ Not Tested Reason: _____ State Medical Exemption

If applicant was previously Positive, indicate date: _____ (mm / dd / yyyy)

Mantoux Result: ☐ Positive ☐ Negative _____ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety? ☐ Yes ☐ No

Signature *(physician, physician's assistant, nurse practitioner OR a registered nurse)*	
Name *(Please PRINT clearly)*	**Title**
( ) -	**/ /**
Phone	**Date**

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